STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 B. WING	08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Recertification and State Licensure Survey. Survey Dates: August 8, 9, 10, 11, 12, 2011 Facility Number: 000215 Provider Number: 155322 AIM Number: 100267600 Survey Team: Sheryl Roth RN TC Rick Blain RN Sue Brooker RD Diane Nilson RN Angie Strass RN Census Bed Type: NF: 61 SNF/NF: 27 Total: 88 Census Payor Type: Medicare: 4 Medicaid: 62 Other: 22 Total: 88 Stage 2 Sample: 32 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 8/17/11 Cathy Emswiller RN			

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F0156 SS=B	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;			

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	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.			

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	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to provide documentation indicating that two days notice was provided regarding pending Medicare non-coverage for 3 of 3 residents reviewed who met the criteria for notification of Medicare non-coverage. (Resident #8, Resident #13, and Resident #7) Findings include; 1. On 8/10/11 at 11:00 a.m., the facility Business Office Manager provided a "Notice of Medicare Provider Non-Coverage" form for Resident #8. The form indicated the effective date of coverage of the resident's current Speech Therapy services was to end 2/17/11. The form was signed and dated by the resident's authorized representative on 3/15/11, indicating the notice was received on that date.	F0156	F156 **CORRECTIVE ACTION FOR AFFECTED RESIDENTS**Corrective actions cannot be accomplished for resident #8, #13 and #7 because the "Notice of Medicare Provider Non-Coverage" letter had already been mailed. The date the residents were to receive their non-coverage notification had passed prior to the facility receiving notice, via the survey process, that the letters lacked documentation of a phone conversation with the responsible party proving the 2 day notice.**IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS**Residents admitted to this facility who receive Medicare skilled services would have the potential to be affected. Future "notice of Medicare provider non-coverage contains documentation of phone contacts made with responsible party to prove that there was indeed a two day notice of the non coverage.**MEASURES FOR**	08/29/2011

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	2. On 8/10/11 at 11:00 a.m., the Business Office Manager provided a "Notice of Medicare Provider Non-Coverage" form for Resident #13. The form indicated that the effective date of coverage of the resident's current Occupational Therapy and Physical Therapy services was to end on 6/6/11. The form was signed and dated by the resident's authorized representative on 6/6/11, indicating the notice was received on that date. 3. On 8/10/11 at 11:00 a.m., the Business Office Manager provided a "Notice of Medicare Provider Non-Coverage" form for Resident #7. The form indicated that the effective date of coverage of the resident's current Speech Therapy services was to end 7/20/11. The form was signed and dated by the resident's authorized representative on 7/28/11, indicating the notice was received on that date. The Business Office Manager was interviewed on 8/10/11 at 11:15 a.m. During the interview, the Business Office Manager indicated if the representative was not in the building, they are contacted by phone prior to the services no longer being covered to inform them of the date services would no longer be covered. The Business Office Manager indicated she contacted the representatives at least two days prior to the date of non-coverage by		**PREVENTION**New non-coverage procedure for Medicare residents will be implemented immediately. Staff have been in-serviced on the procedure on 8/29/11.**QA FOR PREVENTION**The corrective actions are monitored by the Business Office Manager and the QA Committee will review monthly for one year.**EFFECTIVE DATE**Compliance date is August 29, 2011.	

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	telephone. The Business Office Manager indicated sometimes the phone contact was documented on the form itself. The Business Office Manager was unable to provide documentation of the residents' representatives being contacted by telephone to inform them of the pending non-coverage. The Business Office Manager indicated the representative for Resident #13 was in the building on 6/6/11, the day she signed the notice. On 8/11/11 at 11:00 a.m., the Business Office Manager provided a form entitled "Non-Coverage Letter Log." The Business Office Manager indicated the log indicated when the residents' representatives were notified of the non-coverage. The log did not indicate the method of notification or who was notified. The log only indicated the date of notice, the resident's name, the type of services, including but not limited to, Physical Therapy, Occupational Therapy, and Speech Therapy, along with the initials of the staff person. The log indicated the representative of Resident #13 was notified on 6/3/11 and the representative of Resident #7 was notified on 7/20/11. The log only went back to 5/26/11 and did not include when the representative of Resident #8 was notified.			

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	An undated facility policy entitled "Noncovered Letters" was provided by the Business Office Manager on 8/11/11 at 11:00 a.m. The Business Office Manager indicated the policy was current. The policy indicated "If the facility noncovers (sic) a patient and does not issue the letter and verbally notify the beneficiary or responsible party, the facility will be liable for all charges and runs the risk of loosing (sic) their favorable waiver status with Medicare." The policy further indicated, "Not only does the letter need to be issued, but the facility must also contact the responsible party verbally. All efforts must be documented on the letter. If you are not able to reach the responsible party, you must document your efforts with the date and the time attempts are made. At least two attempts should be made." 3.1-4(a)			
F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.			

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	Based on interview and record review, the facility failed to prevent verbal and physical abuse of residents from staff. This affected 2 of 4 residents reviewed for abuse in the sample of 14 who met the criteria for abuse. (Resident #45, and #84) Findings include: 1. Review of the clinical record of Resident #45 on 8/10/11 at 10:43 a.m., indicated the following: diagnoses included, but were not limited to, anxiety, depression, dementia, and Alzheimer's type with depression. Resident #45 was interviewed on 8/9/11 at 9:00 a.m. During the interview she indicated she was afraid of a particular CNA who had caused bruising to her bilateral forearms while she was being given a morning bed bath. She indicated the CNA had grabbed her arms when she was attempting to turn from side to side in her bed. She also indicated she showed the bruising to the nurse but did not report the incident to the Administrator. She further indicated the CNA has a temper and understood she received a suspension over the incident. The CNA has not taken care of her since. Resident #45 could not recall the name of the CNA.	F0223	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* The alleged allegations from resident #45 and #84 were investigated per facility policy at the time the alleged allegations occurred and reported to the ISDH per state regulation. The staff members' involved (CNA #14 & #15) received disciplinary action of termination after the investigation was completed. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* Renaissance Village continues to follow the facility policy "Abuse Prevention" to provide guidance on hiring employees. The policy requires an extensive criminal background check, prior employee reference check, validation of nursing aide register check, OIG list, and sexual offenders list. The policy also incorporates guidance on reporting and investigating mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property. An in-service will be provided for all staff related to staff treatment to residents. *MEASURES FOR PREVENTION* Renaissance Village continues to educate all new employees regarding the policy, "Staff Treatment to Resident" emphasizing the guideline of NO TOLERENCE. Education continues upon hiring, annually, and	09/11/2011

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	Nurse's notes dated 3/2/11 to 8/10/11 were reviewed on 8/10/11 at 1:20 p.m. There was no indication in the nurse's notes Resident #45 had any bruising to her bilateral arms. Nursing admission assessments, dated 5/23/10, 7/9/10, 10/14/10, and 3/21/11, did not indicate any bruising to bilateral arms. LPN #3 was interviewed on 8/10/11 at 2:50 p.m. During the interview she indicated Resident #45 had moved from the skilled wing to the 100 hall in 3/2011. Since being on the 100 hall, LPN #3 indicated she had not had any bruising to her bilateral forearms. RN #8 was interviewed on 8/10/11 at 2:53 p.m. During the interview she indicated she had worked with Resident #45 when she lived on the skilled wing. She also indicated she could not recall any bruising to her bilateral arms. Social Service #16 was queried concerning any allegation of abuse made by Resident #45 concerning staff on 8/10/11 at 10:10 a.m. She indicated she could not locate any report of alleged abuse involving the bruising of her bilateral arms, but provided an incident report, dated 12/23/10, between Resident		on an as needed basis. Renaissance Village continues to investigate all allegations of abuse/neglect and provide disciplinary actions as deemed appropriate up to and including termination. *QA FOR PREVENTION* All allegations of abuse/neglect will continue to be investigated immediately with appropriate disciplinary measures enforced. The investigation will be placed on a spreadsheet by the DON or designee for review during the monthly QA&A meeting and recommendations for potential policy change will be directed at that time. *EFFECTIVE DATE* The changes are completed and effective by September 11, 2011.	

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	#45 and CNA #14. A facility investigation into alleged abuse, dated 12/23/10, indicated CNA #14 had been reported due to alleged verbal abuse of a resident by staff. Two CNA's who were assisting CNA #14 with Resident #45, indicated Resident #45 was yelling and trying to hit at CNA #14. CNA #14 told Resident #45 to stop it and not to hit her. CNA #14 laughed, smiled and stated "I love it when she's like this." Resident #45 then yelled at CNA #14 and told her to stop snapping her gum, that she hated it when she did that. CNA #14 laughed and continued to snap her gum. CNA #14 was suspended during the investigation and terminated on 12/24/10. Nurse's notes for Resident #45, dated 12/23/10 at 5:00 p.m., indicated the Assistant Director of Nursing (ADON) informed the writer earlier in the day a 1st shift CNA was accused of being verbally abusive to Resident #45. The CNA was suspended until further investigation. Resident #45's physician and family were notified. Nurse's notes for Resident #45, dated 12/24/10 at 12:10 a.m., indicated no adverse effects noted from the incident. The DON was interviewed on 8/11/11 at			

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	10:22 a.m. During the interview she indicated the facility dismissed CNA #14 due to her continuing tone of voice and attitude. 2. Review of the clinical record for Resident #84 on 8/12/11 at 11:15 a.m., indicated the following: diagnoses included, but were not limited to, severe osteoporosis, polymyalgia rheumatica, and history of Bells palsy. Nurse's notes for Resident #84, dated 8/8/11 at 3:39 p.m., indicated Resident #84's roommate (Resident #42) reported to writer a CNA told Resident #84 to take off her blouse and pants, using a rough voice. Resident #42 also indicated Resident #84 cannot undress herself. Nurse's notes for Resident #84, dated 8/8/11 at 9:00 p.m., indicated the ADON informed the writer that Resident #42 stated CNA #15 told Resident #84 to put her own clothes on, in a rough voice. Resident #84 was asked about the incident but could not recall anyone being rough with her. Resident #42's stated "she talked rough to you last night." No adverse effects were noted from the incident. Resident #84 will continue to be monitored. The nurse's note also indicated CNA #15 was sent home			

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	pending further investigation. Nurse's notes for Resident #84, dated 8/8/11 at 10:50 p.m., indicated Resident #84 could not remember the incident with the CNA. Resident #42 stated "A CNA was rough with her et (and) told her to put her own clothes on." The nurse's note also indicated there were no adverse effects noted to the resident from the incident with the CNA. Nurse's notes for Resident #84, dated 8/9/11 at 8:15 a.m., indicated her POA was notified of the incident. A minimum data set (MDS) assessment for Resident #84, dated 5/5/11, listed a Brief Interview of Mental Status (BIMS) score of 7/15, indicating severe cognitive impairment. The MDS also indicated Resident #84 required extensive assistance with the physical assistance of one staff for dressing. A facility care plan for Resident #84, with a reviewed date of 8/11, indicated she needs extensive assistance with ADL's (Activities of Daily Living) due to severe osteoporosis. Nursing interventions included, but were not limited to, assist Resident #84 to dress daily. A facility investigation into alleged abuse,			

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	dated 8/10/11, indicated CNA #15 had used a rough tone of voice to Resident #84 as reported by her roommate (Resident #42). Resident #42's had voiced a concern that a CNA had told Resident #84 to take off her blouse and pants in a rough tone of voice. Resident #42 stated Resident #84 is unable to take her own clothes off. CNA #15 was suspended during the investigation and terminated on 8/11/11 for unprofessional behaviors. The MDS for Resident #42, dated 6/1/11, indicated a BIMS score of 15/15, indicating she was cognitively intact. The Administrator was interviewed on 8/12/11 at 11:15 a.m., during the interview, the Administrator indicated the facility had a zero tolerance policy for abuse. A current undated facility policy "Abuse Prevention", was provided by the Administrator on 8/11/11 at 3:30 p.m., "...The facility shall ensure, to the best of its ability, that residents are free from verbal...abuse...Verbal abuse: any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents...or within heating distance, regardless of their age, ability to comprehend, or disability...."			

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	3.1-27(b)			
F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			

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	155322	A. BUILDING 00 B. WING	08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN46814

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	Based on interview and record review, the facility failed to prevent verbal and physical abuse of residents from staff. This affected 2 of 4 residents reviewed for abuse in the sample of 14 who met the criteria for abuse. (Resident #45, and #84) Findings include: 1. Review of the clinical record of Resident #45 on 8/10/11 at 10:43 a.m., indicated the following: diagnoses included, but were not limited to, anxiety, depression, dementia, and Alzheimer's type with depression. Resident #45 was interviewed on 8/9/11 at 9:00 a.m. During the interview she indicated she was afraid of a particular CNA who had caused bruising to her bilateral forearms while she was being given a morning bed bath. She indicated the CNA had grabbed her arms when she was attempting to turn from side to side in her bed. She also indicated she showed the bruising to the nurse but did not report the incident to the Administrator. She further indicated the CNA has a temper and understood she received a suspension over the incident. The CNA has not taken care of her since. Resident #45 could not recall the name of the CNA. Nurse's notes dated 3/2/11 to 8/10/11 were	F0225	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* The alleged allegations from resident #45 and #84 were investigated per facility policy at the time the alleged allegations occurred and reported to the ISDH per state regulation. The staff members' involved (CNA #14 & #15) received disciplinary action of termination after the investigation was completed. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* Renaissance Village continues to follow the facility policy "Abuse Prevention" to provide guidance on hiring employees. The policy requires an extensive criminal background check, prior employee reference check, validation of nursing aide register check, OIG list, and sexual offenders list. The policy also incorporates guidance on reporting and investigating mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property. An in-service will be provided for all staff related to staff treatment to residents. *MEASURES FOR PREVENTION* Renaissance Village continues to educate all new employees regarding the policy, "Staff Treatment to Resident" emphasizing the guideline of NO TOLERENCE. Education continues upon hiring, annually, and	09/11/2011

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	reviewed on 8/10/11 at 1:20 p.m. There was no indication in the nurse's notes Resident #45 had any bruising to her bilateral arms. Nursing admission assessments, dated 5/23/10, 7/9/10, 10/14/10, and 3/21/11, did not indicate any bruising to bilateral arms. LPN #3 was interviewed on 8/10/11 at 2:50 p.m. During the interview she indicated Resident #45 had moved from the skilled wing to the 100 hall in 3/2011. Since being on the 100 hall, LPN #3 indicated she had not had any bruising to her bilateral forearms. RN #8 was interviewed on 8/10/11 at 2:53 p.m. During the interview she indicated she had worked with Resident #45 when she lived on the skilled wing. She also indicated she could not recall any bruising to her bilateral arms. Social Service #16 was queried concerning any allegation of abuse made by Resident #45 concerning staff on 8/10/11 at 10:10 a.m. She indicated she could not locate any report of alleged abuse involving the bruising of her bilateral arms, but provided an incident report, dated 12/23/10, between Resident #45 and CNA #14.		on an as needed basis. Renaissance Village continues to investigate all allegations of abuse/neglect and provide disciplinary actions as deemed appropriate up to and including termination. *QA FOR PREVENTION* All allegations of abuse/neglect will continue to be investigated immediately by the departments manager with appropriate disciplinary measures enforced. The investigation will be placed on a spreadsheet by the DON or designee for review during the monthly QA&A meeting and recommendations for potential policy change will be directed at that time. *EFFECTIVE DATE* The changes are completed and effective by September 11, 2011.	

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A facility investigation into alleged abuse, dated 12/23/10, indicated CNA #14 had been reported due to alleged verbal abuse of a resident by staff. Two CNA's who were assisting CNA #14 with Resident #45, indicated Resident #45 was yelling and trying to hit at CNA #14. CNA #14 told Resident #45 to stop it and not to hit her. CNA #14 laughed, smiled and stated "I love it when she's like this." Resident #45 then yelled at CNA #14 and told her to stop snapping her gum, that she hated it when she did that. CNA #14 laughed and continued to snap her gum. CNA #14 was suspended during the investigation and terminated on 12/24/10.

Nurse's notes for Resident #45, dated 12/23/10 at 5:00 p.m., indicated the Assistant Director Of Nursing informed the writer earlier in the day a 1st shift CNA was accused of being verbally abusive to Resident #45. The CNA was suspended until further investigation. Resident #45's physician and family were notified.

Nurse's notes for Resident #45, dated 12/24/10 at 12:10 a.m., indicated no adverse effects noted from the incident.

The DON was interviewed on 8/11/11 at 10:22 a.m. During the interview she

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	155322	A. BUILDING 00 B. WING	08/12/2011

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	indicated the facility dismissed CNA #14 due to her continuing tone of voice and attitude. 2. Review of the clinical record for Resident #84 on 8/12/11 at 11:15 a.m., indicated the following: diagnoses included, but were not limited to, severe osteoporosis, polymyalgia rheumatica, and history of Bells palsy. Nurse's notes for Resident #84, dated 8/8/11 at 3:39 p.m., indicated Resident #84's roommate reported to writer a CNA told Resident #84 to take off her blouse and pants, using a rough voice. The roommate also indicated Resident #84 cannot undress herself. Nurse's notes for Resident #84, dated 8/8/11 at 9:00 p.m., indicated the ADON informed the writer the roommate of Resident #84 stated CNA #15 told the resident to put her own clothes on, in a rough voice. Resident #84 was asked about the incident but could not recall anyone being rough with her. Resident #84's roommate stated "she talked rough to you last night." No adverse effects were noted from the incident. Resident #84 will continue to be monitored. The nurse's note also indicated CNA #15 was sent home pending further investigation.			

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Nurse's notes for Resident #84, dated 8/8/11 at 10:50 p.m., indicated Resident #84 could not remember the incident with the CNA. The roommate of Resident #84 stated "A CNA was rough with her et (and) told her to put her own clothes on." The nurse's note also indicated there were no adverse effects noted to the resident from the incident with the CNA.

Nurse's notes for Resident #84, dated 8/9/11 at 8:15 a.m., indicated her POA was notified of the incident.

A Minimum Data Set (MDS) Assessment for Resident #84, dated 5/5/11, indicated a Brief Interview of Mental Status (BIMS) score of 7/15, indicating severe cognitive impairment. The MDS also indicated Resident #84 required extensive assistance with the physical assistance of one staff for dressing.

A facility care plan for Resident #84, reviewed on 8/11, indicated she needs extensive assistance with ADL's (Activities of Daily Living) due to severe osteoporosis. Nursing interventions included, but were not limited to, assist Resident #84 to dress daily.

A facility investigation into alleged abuse, dated 8/10/11, indicated CNA #15 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 B. WING	08/12/2011

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RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN46814

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	used a rough tone of voice to Resident #84 as reported by her roommate. Resident #84's roommate had voiced a concern that a CNA had told Resident #84 to take off her blouse and pants in a rough tone of voice. Resident #84's roommate stated Resident #84 is unable to take her own clothes off. CNA #15 was suspended during the investigation and terminated on 8/11/11 for unprofessional behaviors. The MDS for Resident #84's roommate, dated 6/1/11, indicated a BIMS score of 15/15, indicating she was cognitively intact. The Administrator was interviewed on 8/12/11 at 11:15 a.m., during the interview, the Administrator indicated the facility had a zero tolerance policy for abuse. A current undated facility policy "Abuse Prevention", provided by the Administrator on 8/11/11 at 3:30 p.m., indicated "...The facility shall ensure, to the best of its ability, that residents are free from verbal...abuse...Verbal abuse: any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents...or within heating distance, regardless of their age, ability to comprehend, or disability...."			

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	155322	A. BUILDING 00 B. WING	08/12/2011

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	3.1-28(e)			
F0253 SS=B	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, record review and interview, the facility failed to ensure 1 of 32 resident's rooms were free of urine odor. (Resident #5) Finding includes: On 8/10/11 at 11:05 a.m., Resident #5 was observed in her room, sleeping in a recliner. There was a strong odor of urine coming from the resident and her chair. On 8/11/11 at 1:30 p.m., review of resident #5's plan of care indicated the resident had occasional incontinence of bladder and a history of urinary tract infections. The resident also had a diagnosis of urge incontinence. On 8/12/11 at 9:00 a.m., Resident #5 was observed in her room, seated in her recliner. There was a strong odor of urine present. An interview was conducted with the Housekeeping Supervisor on 8/12/11 at 10:25 a.m. During the Interview, she	F0253	**F 253CORRECTIVE ACTION FOR AFFECTED RESIDENTS:**Carpet and bathroom floor cleaned in resident #5's room 8/22/11. Walls washed with a sanitizing solution. On 8/23/11 bathroom floor cleaned with enzyme cleaner. Bathroom continued to have urine smell and was again cleaned with enzyme cleaner on 8/24/11. Bathroom floor sprayed with enzyme cleaner on 8/25/11. New flooring ordered for bathroom.**IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS**Any room with a strong urine smell will be reported to environmental services.**MEASURES FOR PREVENTION:**Environmental manager or designee weekly will tour facility to monitor for strong smells.**QA FOR PREVENTION:**Environmental manager will monitor facility weekly for strong orders and environmental QA form for problem areas will be used to track interventions which will be presented at monthly QA& A meetings.**EFFECTIVE**	09/11/2011

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	155322	A. BUILDING 00 B. WING	08/12/2011

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	indicated Resident #5's carpet was cleaned monthly and as needed. She also indicated the facility cleans the resident's recliners. On 8/12/11 at 10:50 a.m., the Housekeeping Supervisor indicated the carpet was cleaned on a monthly basis, and she presented the carpet cleaning schedules. Review of resident #5's carpet cleaning schedule indicated it had been cleaned on 6/24/11, 7/5/11 and had not been cleaned for August. The Housekeeping Supervisor also indicated Resident #5's recliner was new, and had not been cleaned yet. She also stated the odor could be the bed. 3.1-18(a)		**DATE:**September 11, 2011 *ADDENDUM* Both mattresses were checked in the room of resident #5. Both mattresses are intact. The mattresses were completely washed with sanitizing solution.	

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F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.			
	Based on record review and interview, the facility failed to revise the care plans for 1 of 2 residents (Resident #17) who were reviewed for dental needs, in a sample of 3 who met the criteria. This also affected 1 of 5 residents who were reviewed for nutritional needs (Resident #42) in a sample of 32 residents who met the criteria for nutritional needs. Findings include: 1. Resident #42's record was reviewed on 8/11/11 at 2:30 p.m. The care plan for "Nutritional Status," originally dated 12/16/09, with a reviewed date of 11/10/10, 12/10/10, 3/11/11, and	F0280	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* The plan of care for resident # 17 and #42 has been reviewed and revised to reflect the resident's current status. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* All residents' care plans regarding pressure areas, use of supplements or recent weight loss in relation to nutrition are at risk to be affected. The plan of care for each of the potentially affected residents have been reviewed and revised as needed. *MEASURES FOR PREVENTION* A review of Renaissance Village's care planning policy has been reviewed and no further changes are recommended at this time.	09/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 B. WING	08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	5/11/11, indicated a problem/need which indicated Resident #17 was on a therapeutic diet due to diabetes mellitus and had no significant changes in weight, had a good appetite, and had distinct food preferences. The goal indicated the resident would consume 75-100% of meals and snacks without significant changes in weight. There was no documentation on the care plan regarding pressure areas, the use of supplements, or recent weight loss. The dietary progress notes, dated 5/31/11, indicated Resident #42 had distinct food preferences, and she was trying to watch her weight. The progress note also indicated the resident currently had a wound to the left buttock, for which zinc and vitamin C had been started, and the resident was refusing prosource (a nutritional supplement), and indicated she couldn't get supplements past her nose. The dietary progress note indicated the current weight was 156 pounds, down 7 pounds (4.3%) from the previous month, over 3 months the weight was down 10 pounds (5.9%) and over 6 months, the resident's weight was down 22 pounds (12.4%). The note also indicated there was a risk for inadequate oral intake due to distinct food preferences, in planning her own menus and trying to lose weight,		The Interdisciplinary team will gather weekly to review eight random care plans for 4 weeks and then monthly to review eight random care plans for six months. The Interdisciplinary Team will continue to meet during the MDS period of annuals, quarterlies, and significant changes to review plan of care records. *QA FOR PREVENTION* All discrepancies found during the review of records will be documented on a spreadsheet by the Interdisciplinary Team, reviewed, and recommendation for potential policy changes made accordingly during the monthly QA&A meeting. *EFFECTIVE DATE*The changes are completed and effective by September 11, 2011. *ADDENDUM* All residents' care plans regarding dental needs will be reviewed for accuracy by September 11, 2011.	

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	and that the resident had been identified as having protein malnutrition. Progress notes, dated 6/20/11, indicated the Stage 2 pressure area to the left buttock continued to be treated and that the resident didn't like any of the nutritional supplements offered to her. Notes dated 7/30/11, indicated the Dietitian had spoken to Resident #42 regarding her food choices and consequences of not eating a balanced diet, and that the resident had continued to voice her desire for weight loss. The Dietary Manager was interviewed on 8/12/11 at 10:10 a.m. During the interview, the Dietary Manager indicated the Dietitian had visited recently. She further indicated the resident would send notes to the dietary department every day regarding what she would eat. The resident had a problem with adequate protein intake and did not like milk or milk products but would eat cottage cheese at times. The "Nutritional Care Plan" for Resident #42 had not been updated to reflect these changes in the resident's condition. 2. Review of the clinical record of Resident #17 on 8/10/11 at 8:33 a.m., indicated the following: diagnoses included, but were not limited to,			

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	155322	A. BUILDING 00 B. WING	08/12/2011

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	dementia with agitation, depression with psychotic features and personality disorder. An admission assessment for Resident #17, dated 5/7/09, indicated she had upper and lower dentures. A current physician's order for Resident #17, dated 7/20/11, indicated she was to receive a mechanical soft diet with pureed meats due to problems with chewing and swallowing. A speech therapy assessment for Resident #17, dated 9/28/10, indicated a mechanical soft diet with puree meat was the safest consistency for her due to increased swallowing difficulty and slow A-P (anterior to posterior) transfer of solids. A facility care plan for Resident #17, with a review date of 6/11, indicated she had upper and lower dentures but does not wear due to her daughter took them home, receives a mechanically altered diet, and is at risk for choking episodes related to her edentulous (no teeth) state. Nursing interventions included, but were not limited to, monitor for increased chewing and swallowing problems. A second facility care plan for Resident			

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	155322	A. BUILDING 00 B. WING	08/12/2011

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	#17, with a review date of 6/11, indicated she required extensive to total assist for activities of daily living (ADL) care. Nursing interventions included, but were not limited to, assist Resident #17 to complete oral care twice daily; she has upper and lower dentures, and apply dentures every morning and remove at bedtime. A third facility care plan for Resident #17, with a review date of 6/11, indicated she tended to leave 25% or more of her food uneaten at meals. Nursing interventions included, but were not limited to, teeth: has upper and lower dentures. Nurses's notes for Resident #17, dated 4/15/11, indicated she needs total assist with feeding and was on a mechanical soft diet. The nurse's note also indicated she has dentures but won't wear them. The daughter of Resident #17 was interviewed on 8/9/11 at 1:30 p.m. During the interview she indicated her mother refused to wear her dentures. She also indicated her mother's dentures had recently been re-fitted, but she still continued to decline to wear them. LPN #3 was interviewed on 8/10/11 at 10:18 a.m.. During the interview she indicated Resident #17 had actually			

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	155322	A. BUILDING 00 B. WING	08/12/2011

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	received a new set of dentures and they were fitted properly. She also indicated Resident #17 refused to wear her dentures and her daughter took them home. CNA #2 was interviewed on 8/10/11 at 10:36 a.m. During the interview she indicated Resident #17 refused to wear her dentures. The Director of Nursing (DON) was interviewed on 8/11/11 at 3:07 p.m. During the interview, she indicated care plans were reviewed during the weekly behavior meetings. She also indicated each discipline was responsible for updating their care plans. A current facility care plan "Documentation", revised on October 2010, indicated "...A plan of care is to be individualized to the resident...With...changes in residents need, the care plan is to be updated...." 3.1-35(d)(2)(B)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			

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	155322	A. BUILDING 00 B. WING	08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, record review and interview, the facility failed to follow the care plan to prevent accidents for 1 of 6 residents reviewed (Resident #12) for accidents who met the criteria. The facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin conditions who met the criteria. Findings include: 1. On 8/11/11 at 10:00 a.m., Resident #12 was observed sitting up in a comfort chair in her room with a seat belt in place. The resident was alert with eyes open. No staff were present in the room. The "Fall Risk Screen," dated 7/25/11, indicated Resident #12 was at risk for falls. The "Falls" care plan for Resident #12, dated 10/3/02 and reviewed 7/11, listed the nursing intervention of "Do not leave alone in room when in chair." The Minimum Data Set (MDS) assessment, dated 7/26/11, indicated Resident #12 had both short and long term memory issues, inattention, disorganized thinking and altered level of	F0282	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* The plan of care for resident #12 has been reviewed and revised on the assignment sheet to include “do not leave alone in room while in wheelchair”. The plan of care for resident #43 has been reviewed and revised on the assignment sheet to include the turning and repositioning program. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* All residents’ assignment sheets are at risk to be potentially affected. A review and revision, if necessary, of all assignment sheets will be conducted. *MEASURES FOR PREVENTION* Any plan of care changes related to the CNA scope of practice will be written on a “Plan of Change” form to be utilized to update the assignment sheet. A copy of the “Plan of Change” form will be directed to the DON or designee. Team Leaders responsible for the update of the assignment sheet will be required to make updates written immediately to the assignment sheet with the typed version being completed by Friday and copy given to the DON or designee for review of all revisions. *QA FOR PREVENTION* A log will be maintained by the DON or designee indicating “Plan of Change” forms submitted, and verification of changes made to	09/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 B. WING	08/12/2011

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	consciousness. The nurse's notes, dated 7/30/11 at 3:45 p.m., indicated the writer was called to Resident #12's room by a CNA. The resident was observed laying sideways on the low bed mat. The resident was alert and grabbing at writer. Stated "get me up." The undated CNA assignment sheet was provided by the Director of Nursing on 8/10/11 at 3:40 p.m. The listing for Resident #12 indicated she was a fall risk but did not include the care plan intervention of not leaving the resident alone in her room while up in a chair. An interview was conducted with CNA #4 on 8/11/11 at 10:15 a.m. During the interview, CNA #4 indicated Resident #12 gets into moods, sometimes grabs things. She further indicated, the resident is usually not left in her room but it was her shower day and Resident #12 was waiting for her CNA to give her a shower, During an interview with CNA #4 on 8/11/11 at 10:45 a.m., CNA #4 indicated all care needs provided to a resident can be found on the CNA assignment sheet. The Director of Nursing (DON) provided a copy of the assignment sheets for 300		the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheet will be reviewed monthly during the QA&A meeting for potential revision of policy. *EFFECTIVE DATE*The changes are completed and effective by September 11, 2011.*ADDENDUM* A copy of the "Plan of Change" form will also be distributed to the corresponding hall for CNA's to sign. This signature will serve as proof of notification of the change.	

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	hall on 8/11/11 at 10:30 a.m. The DON indicated the information, "do not leave alone in room" should be listed on the care sheets under safety. 2. The record for Resident #43 was reviewed on 8/10/11 at 1:00 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia and pemphigus bullous (chronic autoimmune skin disease involving the formation of blisters). On 8/10/11 at 1:30 p.m., staff were observed to provide a treatment to Resident #43's buttocks. The resident's buttocks were observed to be reddened with three superficial open areas. An open area on the right mid buttock was approximately 0.5 cm (centimeters) by 1 cm with superficial depth. An open area on the left upper buttock was approximately 0.5 cm by 0.5 cm with superficial depth. An open area on the lower left buttock was approximately 0.5 cm by 0.5 cm with superficial depth. A physician's order monthly recap for 8/2011 indicated Resident #43 had orders to "keep off bottom." A care plan for Resident #43 for skin integrity, with a start date of 11/17/2009 and a goal date of 10/2011, indicated the resident "is at risk of a decline in skin			

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	integrity D/T (due to) DX (diagnosis) Alzheimer's and Decreased Level of Function. (Resident #43) has pemphigus which causes open lesions to buttocks and other areas of body." Interventions listed on the care plan included, but were not limited to, turning and repositioning every two hours. A care plan for Resident #43 for activities of daily living, with a start date of 11/17/09 and a goal date of 10/2011, indicated the resident "needs cuing at times with her ADLs (activities of daily living) D/T Alzheimer's and Decreased Level of Function." Interventions listed on the care plan included, but were not limited to, turning and repositioning approximately every two hours when in bed or in wheelchair. A Braden's Scale Skin Assessment Tool for Resident #43, dated 7/12/11, indicated the resident's mobility was "very limited" and was able to make "occasional slight changes in body or extremity position but unable to make frequent or significant changes independently." On 8/11/11, the following continual observations were made:			

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	8:30 a.m. to 8:45 a.m.: Resident #43 was sitting up in a wheelchair in the 100 hallway. 8:45 a.m.: unidentified staff were observed to transport the resident from the 100 hall to the main dining room for breakfast. 8:45 a.m. until 9:30 a.m.: Observed in the main dining room in a wheelchair eating breakfast. 9:30 a.m.: unidentified staff were observed to transport the resident from the main dining room to the resident's room. The staff positioned the resident in front of the television and left the room. During continual observations from 9:30 a.m. until 11:20 a.m., Resident #43 was observed to be in her wheelchair in her room in front of the television. No staff were observed to enter the room during the observation. 11:15 a.m.: Staff were observed to enter Resident #43's room and transport the resident to the main dining room. The staff was not observed to reposition the resident. During continual observation from 11:15 a.m. until 12:00 p.m., Resident #43 was			

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	observed to be in her wheelchair in the main dining room in a group activity. Staff were not observed to reposition the resident during the observation. CNA #11 was interviewed on 8/11/11 at 2:15 p.m. During the interview, CNA #11 indicated all residents in wheelchairs were to be repositioned every two hours. LPN #3 was interviewed on 8/11/11 at 2:30 p.m. During the interview, LPN #3 indicated all residents in wheelchairs were routinely repositioned every two hours. A facility policy titled "Wound Care and Prevention", with a revised date of March 2011, indicated residents were to be repositioned approximately every two hours when in chairs or in bed. 3.1-35(g)(2)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to re-position a resident in her wheelchair as care	F0309	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* The plan of care for resident #12 has been reviewed and revised on the	09/11/2011

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	planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin conditions who met the criteria. The facility further failed to assess in a timely manner a new skin condition. This affected 1 of 7 residents (Resident #84) who met the criteria for skin conditions, in a sample of 32. Findings include: 1. The record for Resident #43 was reviewed on 8/10/11 at 1:00 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia and pemphigus bullous (chronic autoimmune skin disease involving the formation of blisters). On 8/10/11 at 1:30 p.m., staff were observed to provide a treatment to Resident #43's buttocks. The resident's buttocks were observed to be reddened with three superficial open areas. An open area on the right mid buttock was approximately 0.5 cm (centimeters) by 1 cm with superficial depth. An open area on the left upper buttock was approximately 0.5 cm by 0.5 cm with superficial depth. An open area on the lower left buttock was approximately 0.5 cm by 0.5 cm with superficial depth. A physician's order monthly recap for 8/2011 indicated Resident #43 had orders		assignment sheet to include “do not leave alone in room while in wheelchair”. The plan of care for resident #43 has been reviewed and revised on the assignment sheet to include the turning and repositioning program. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* All residents' assignment sheets are at risk to be potentially affected. A review and revision, if necessary, of all assignment sheets will be conducted. *MEASURES FOR PREVENTION* Any plan of care changes related to the CNA scope of practice will be written on a “Plan of Change” form to be utilized to update the assignment sheet. A copy of the “Plan of Change” form will be directed to the DON or designee. Team Leaders responsible for the update of the assignment sheet will be required to make updates written immediately to the assignment sheet with the typed version being completed by Friday and copy given to the DON or designee for review of all revisions. *QA FOR PREVENTION* A log will be maintained by the DON or designee indicating “Plan of Change” forms submitted, and verification of changes made to the assignment sheets. Any discrepancy from the “Plan of Change” to the assignment sheet will be reviewed monthly during	

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	to "keep off bottom." A care plan for Resident #43 for skin integrity, with a start date of 11/17/2009 and a goal date of 10/2011, indicated the resident "is at risk of a decline in skin integrity D/T (due to) DX (diagnosis) Alzheimer's and Decreased Level of Function. (Resident #43) has pemphigus which causes open lesions to buttocks and other areas of body." Interventions listed on the care plan included, but were not limited to, turning and repositioning every two hours. A care plan for Resident #43 for activities of daily living, with a start date of 11/17/09 and a goal date of 10/2011, indicated the resident "needs cuing at times with her ADLs (activities of daily living) D/T Alzheimer's and Decreased Level of Function." Interventions listed on the care plan included, but were not limited to, turning and repositioning approximately every two hours when in bed or in wheelchair. A Braden's Scale Skin Assessment Tool for Resident #43, dated 7/12/11, indicated the resident's mobility was "very limited" and was able to make "occasional slight changes in body or extremity position but		the QA&A meeting for potential revision of policy. *EFFECTIVE DATE*The changes are completed and effective by September 11, 2011.*ADDENDUM CORRECTIVE ACTION FOR AFFECTED RESIDENTS* The plan of care for resident #43 has been reviewed and revised on the assignment sheet to include the turning and repositioning program provided by CNA's. An immediate assessment and investigation was completed on resident #84 during the survey process.*IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS*All residents' assignment sheets are at risk to be potentially affected. A review and revision, if necessary, of all assignment sheets will be conducted. Nurses complete on a weekly basis a form titled "Weekly Summary". Part of the "Weekly Summary" includes assessment of the resident's skin. Additionally, CNA's provide daily inspection of the skin as part of their ADL care and report any new skin issue to the nurse for follow-up. *MEASURES FOR PREVENTION*Any plan of care changes related to the CNA scope of practice will be written on a "Plan of Change" form to be utilized to update the assignment sheet. A copy of the "Plan of Change" form will be directed to the DON or designee. Team Leaders responsible for the	

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	unable to make frequent or significant changes independently." On 8/11/11, the following continual observations were made: 8:30 a.m. to 8:45 a.m.: Resident #43 was sitting up in a wheelchair in the 100 hallway. 8:45 a.m.: Staff were observed to transport the resident from the 100 hall to the main dining room for breakfast. 8:45 a.m. until 9:30 a.m.: Observed in the main dining room in a wheelchair eating breakfast. 9:30 a.m.: Staff were observed to transport the resident from the main dining room to the resident's room. The staff positioned the resident in front of the television and left the room. During continual observations from 9:30 a.m. until 11:20 a.m., Resident #43 was observed to be in her wheelchair in her room in front of the television. No staff were observed to enter the room during the observation. 11:15 a.m.: Staff were observed to enter Resident #43's room and transport the resident to the main dining room. The		update of the assignment sheet will be required to make updates written immediately to the assignment sheet with the typed version being completed by Friday and copy given to the DON or designee for review of all revisions. The DON or designee will monitor four records weekly from the "24-Hour Report" for four weeks, then 4 records monthly times five months with assessment of the resident for potential bruising after an incident has been reported. Any discovered discrepancies will be addressed immediately. CNA's will be inserviced regarding updating of assignment sheets through the "Plan of Change" form and nurses will be inserviced regarding timely assessment of skin. *QA FOR PREVENTION*A log will be maintained by the DON or designee indicating "Plan of Change" forms submitted, and verification of changes made to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheet will be reviewed monthly during the QA&A meeting for potential revision of policy. *EFFECTIVE DATE* The changes are completed and effective by September 11, 2011.	

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	staff was not observed to reposition the resident. During continual observation from 11:15 a.m. until 12:00 p.m., Resident #43 was observed to be in her wheelchair in the main dining room in a group activity. Staff were not observed to reposition the resident during the observation. CNA #11 was interviewed on 8/11/11 at 2:15 p.m. During the interview, CNA #11 indicated all residents in wheelchairs were to be repositioned every two hours. LPN #3 was interviewed on 8/11/11 at 2:30 p.m. During the interview, LPN #3 indicated all residents in wheelchairs were routinely repositioned every two hours. A facility policy titled "Wound Care and Prevention", with a revised date of March 2011, indicated residents in were to be repositioned approximately every two hours when in chairs or bed. 2. On 8/8/11 at 12:00 p.m., Resident #84 was observed in her bed. Two purplish/blue bruises, one centimeter in size. One was observed on the resident's right upper arm and one on the left upper arm. Resident #84's record was reviewed on			

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	8/10/11 at 1:15 p.m. There was no documentation regarding any bruises on the resident's arms. RN #8 was interviewed on 8/10/11 at 3:30 p.m. During the interview, RN #8 indicated she was unaware of the bruises on the resident's arms, but if they had been assessed, documentation would be in the treatment book. RN #8 was interviewed on 8/10/11 at 3:38 p.m. During the interview, RN #8 indicated she had assessed the bruises on the resident's arms and had measured the bruises. The Assistant Director of Nursing was interviewed on 8/11/11 at 1:10 p.m., regarding the bruises on Resident #84's arms. She indicated there was no documentation of the bruises being assessed in the resident's record. She further indicated an assessment had been completed and an investigation was being done regarding the bruising. She also indicated the resident was on medication which could increase her risk of bruising. 3.1-37(a)			

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F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview, the facility failed to provide proper catheter care for 1 of 3 residents reviewed for indwelling urinary catheters (Resident #34) who met the criteria by cleaning the catheter tubing from the perineal area and outward. The facility further failed to ensure perineal care was provided by wiping the resident from front to back and from the center of the perineum outward. Findings include: LPN #3 was interviewed on 8/8/11 at 2:15 p.m. During the interview, LPN #3 indicated Resident #43 had a Foley catheter (indwelling urinary catheter) due to a diagnosis of urinary retention. The record for Resident #43 was reviewed on 8/10/11 at 1:00 p.m. Diagnoses included, but were not limited to, urinary retention and Alzheimer's dementia.	F0315	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* Resident #43 has been observed and is receiving appropriate catheter care/maintenance per facility policy. All nursing staff will be reeducated through in-servicing and return demonstration regarding the policy for "Perineal Care" which includes catheter care/maintenance. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* All residents utilizing catheters have the potential to be affected. All nursing staff will be reeducated through in-servicing and return demonstration regarding the policy for "Perineal Care" which includes catheter care/maintenance. *MEASURES FOR PREVENTION* The facility's policy for catheter care has been reviewed and no changes are indicated at this time. The nursing staff will be reeducated on the policy related to catheter care with return demonstration required. Continued education will be implemented to include as needed	09/11/2011

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	The record indicated the physician had diagnosed Resident #43 with urinary tract infections and had initiated antibiotic therapy on 5/23/11, 6/13/11, 7/2/11, and 8/1/11. A care plan for Resident #43 for urinary elimination, with a start date of 11/17/09 and a goal date of 10/2011, indicated the resident had a diagnosis of urinary incontinence, urinary retention and had a history of urinary tract infections. The care plan indicated the resident was to receive catheter care twice daily. On 8/11/11 at 8:00 a.m., CNA #2 was observed to provide perineal care and catheter care for Resident #43 in her room. CNA #2 was observed to use a wet wash cloth to clean the resident's perineal area. CNA #2 was observed to wipe the resident with the wash cloth, starting near the anal area and toward the perineal area. CNA #2 was then observed to clean the resident's upper inner thighs with a clean wash cloth, wiping from the inner thighs towards the perineal area. CNA #2 was then observed to use a clean wash cloth to clean the catheter tubing, wiping the tubing toward the perineal area. CNA #2 was interviewed on 8/11/11 at 8:30 a.m. after providing the care to Resident #43. During the interview, CNA		in-servicing for increased presence of infection and continued return demonstration bi-annually. *QA FOR PREVENTION* Review of facility infections for UTI will continue monthly. Each resident will now have an "Infection Tracking Form" updated per the Infection Preventionist as infections occur. Any repeat infection per resident or trending of infection identified per unit will be discussed at the monthly QA&A meeting. Any revision to policy, reeducation or disciplinary action will be discussed. *EFFECTIVE DATE* The changes are completed and effective by September 11, 2011.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#2 indicated that during cleaning of a resident's perineal area, the resident was to be cleaned from the perineal area outward and from front to back. CNA #2 further indicated the catheter tubing was to be cleaned by wiping from the meatus downward. The Nurse Practitioner (NP) was interviewed on 11/12/11 at 10:45 a.m. During the interview, the NP indicated proper catheter care and perineal care would help reduce the risk of Resident #43 getting urinary tract infections. A facility policy titled "Perineal Care, with a revision date of April 2011, indicated to clean catheter tubing, staff were to "gently wipe four inches of catheter from meatus out...." The policy further indicated "...wipe resident from front to back and from center of perineum to thighs...." The policy further indicated that for females staff were to "...separate labia, wash urethra area first. Wash between and outside labia in downward strokes, alternating from side to side and moving outward towards the thighs...." 3.1-41(a)(2)			

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	155322	A. BUILDING 00 B. WING	08/12/2011

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F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure water temperatures in resident rooms on 1 of 3 halls were not to hot and within the acceptable temperature range for safety. The facility further failed to monitor a resident left unattended in the resident's room. This affected 1 of 6 residents (#12) reviewed for accidents in a sample of 32. This had the potential to affect 28 of the 28 residents on the 200 hall. Findings include: 1. On 8/8/11 at 3:42 p.m., water temperatures were checked in resident bathroom sinks on three halls of the facility with the Environmental Director and Maintenance Man #19. The water temperature in resident room 207 was noted to be 125.6 degrees F. The water temperature in resident room 212 was noted to be 127.4 degrees F. Maintenance Man #19 indicated the water heater for the 200 hall was located in the furnace room on the 200 hall. The heater in the furnace room was observed and read at 107 degrees, but as Maintenance	F0323	**F323CORRECTIVE ACTION FOR AFFECTED RESIDENTS:**Hot water was turned off 8/8/11 until plumber could repair. Staff advised that hot water could be obtained from 100 or 300 halls. Mixing valve repair completed and water temperatures monitored by Maintenance supervisor and Plumber 1/2 hour before hot water supplied to resident rooms. Water temperatures then taken in resident rooms and found to be between 100-120°F. The plan of care for resident #12 has been reviewed and revised on the assignment sheet to include “do not leave alone in room while in wheelchair”. IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTSWater temperatures continue to be monitored daily with temperatures taken in 2 rooms on each hall at different times of the day. All residents’ assignment sheets are at risk to be potentially affected. A review and revision, if necessary, of all assignment sheets will be conducted. **MEASURES FOR PREVENTION:**Water temperatures continue to be monitored daily with temperatures taken in 2 rooms on each hall at	08/12/2011

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	Man #19 was reading the heater gage, it was noted to go from 107 degrees to 124 degrees. Maintenance Man #19 indicated there must be a problem with the mixing valve. At 4:26 p.m. on 8/8/11, Maintenance Man #19 indicated he had lowered the temperature on the mixing valve and was trying to get the temperatures down. He indicated he would monitor the water temperatures every 10 minutes until the problem was fixed. He indicated the water temperatures were checked on a daily basis, two resident rooms per hall, and the rooms were rotated as well as the time the checks were completed. On 8/8/11 at 4:30 p.m., the Administrator was interviewed. During the interview, the Administration indicated a plumber had been contacted and was coming today to fix the water heater. She indicated the hot water on the 200 hall was going to be shut off until the problem was fixed. The undated "Roster Sample Matrix" was provided by the Administrator on 8/8/11 at 11:00 a.m. The form listed 28 residents residing on the 200 hall.		different times of the day. Any plan of care changes related to the CNA scope of practice will be written on a "Plan of Change" form to be utilized to update the assignment sheet. A copy of the "Plan of Change" form will be direct to the DON or designee. Team Leaders responsible for the update of the assignment sheet will be required to make immediate written updates to the assignment sheet with the typed version being completed by Friday and copy given to the DON or designee for review of all revisions.QA FOR PREVENTION:Maintenance Supervisor monitors water temperatures on weekly check sheets and reports any trends that will be presented at the monthly QA&A meeting. A log will be maintained by the DON or designee indicating "Plan of Change" forms submitted, and verification of changes made to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheet will be reviewed monthly during the QA&A meeting for potential revision of policy.**EFFECTIVE DATE:**8/12/11 for environmental9/11/11 for nursing *ADDENDUM* CNA's will be inserviced regarding Resident #12 plan of care.	

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	2. On 8/11/11 at 10:00 a.m., Resident #12 was observed sitting up in a comfort chair in her room with a seat belt in place. The resident was alert with eyes open. No staff were present in the room. The "Fall Risk Screen," dated 7/25/11, indicated Resident #12 was at risk for falls. The "Falls" care plan for Resident #12, dated 10/3/02 and reviewed 7/11, listed the nursing intervention of "Do not leave alone in room when in chair." The minimum data set (MDS) assessment, dated 7/26/11, indicated Resident #12 had both short and long term memory issues, inattention, disorganized thinking and altered level of consciousness. The nurse's notes, dated 7/30/11 at 3:45 p.m., indicated the writer was called to Resident #12's room by a CNA. The resident was observed laying sideways on the low bed mat. The resident was alert and grabbing at writer. Stated "get me up." The undated CNA assignment sheet was provided by the Director of Nursing (DON) on 8/10/11 at 3:40 p.m. The listing for Resident #12 indicated she was at fall risk but did not include the care			

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	plan intervention of not leaving the resident alone in her room while up in a chair. An interview was conducted with CNA #4 on 8/11/11 at 10:15 a.m. During the interview, CNA #4 indicated Resident #12 gets into moods sometimes and grabs things. She further indicated, the resident is usually not left in her room but it was her shower day and Resident #12 was waiting for her CNA to give her a shower, During an interview with CNA #4 on 8/11/11 at 10:45 a.m., she indicated all care needs provided to a resident can be found on the CNA assignment sheet. The DON provided a copy of the assignment sheets for 300 hall on 8/11/11 at 10:30 a.m. The DON indicated the information, "do not leave alone in room" should be listed on the care sheets under safety. 3.1-19(c) 3.1-45(a)(1) 3.1-45(a)(2)			

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F0441 SS=F	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review, and interview the facility failed to ensure staff practiced proper handwashing and cleaning of scissors while providing treatment and a dressing change for 1 of 1	F0441	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* Resident #43 has been observed for proper treatment and dressing change and is currently receiving appropriate care/maintenance as	09/11/2011

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	resident (Resident #43) observed for treatment and dressing changes) of 8 residents reviewed who met the criteria for non-pressure related skin conditions. The facility also failed to ensure staff provided proper catheter care for 1 of 1 residents (Resident #43) observed for catheter care of 3 residents reviewed who met the criteria for in-dwelling urinary catheters. The facility further failed to ensure staff practiced proper handwashing following the administration of 2 of 3 insulin injections randomly observed. The facility also failed to maintain an infection control program which investigated, monitored and analyzed infection control data for the prevention of the spread of infections. This had the potential to affect 88 of 88 residents. Findings include: 1. The record for Resident #43 was reviewed on 8/10/11 at 1:00 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, pemphigus bullous (chronic autoimmune skin disease involving the formation of blisters), and urinary retention. On 8/10/11 at 1:30 p.m., RN #1 was observed to provide a treatment and dressing change on the buttocks of Resident #43. Resident #43 was observed		per facility's policy and procedure for hand-washing and cleaning of utilized equipment. All nursing staff will be reeducated through in-servicing and return demonstration for hand-washing and dressing changes. Additionally, resident #43 has been observed and is receiving proper catheter care/maintenance per facility policy. All nursing staff will be reeducated through in-servicing and return demonstration regarding the policy for "Perineal Care" which includes catheter care/maintenance. LPN #13 and RN #10 have been educated for proper hand-washing after administering an insulin injection. All nurses will be attending in-servicing and return demonstration of hand-washing policies. Review of policies related to infection control and isolation have been reviewed and updated to include individual logs for resident infection tracking and differentiating the different types of isolation with direct explanation of each type of isolation. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* All residents receiving wound care with dressing changes, catheter care, and those receiving medication after insulin injections have the potential for risk. Additionally, all residents have the potential for risk for recurrent infection. All nursing staff will be	

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	155322	A. BUILDING 00 B. WING	08/12/2011

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	in her room, lying in bed on her left side. The resident's buttocks were observed to be reddened with three superficial open areas. RN #1 was observed to place her supplies, including scissors, directly on the overbed table without cleaning the table first. RN #1 was observed to put on exam gloves without first washing her hands. The nurse was observed to clean the resident's buttocks with gauze and normal saline. The nurse picked up the scissors from the overbed table and used them to cut Xeroform gauze (petroleum covered gauze) without disinfecting the scissors. The nurse then placed small pieces of the gauze onto the open areas on the resident's buttocks. The nurse then placed the scissors directly onto the overbed table. The resident then began to have a bowel movement. The nurse removed the gloves and went to a dresser in the room and removed a roll of toilet paper. The nurse did not wash her hands after removing the gloves. The nurse then put on a new pair of exam gloves without first washing her hands and proceeded to use the toilet paper to wipe the resident's buttocks. The nurse then indicated she had to get some more supplies. The nurse was observed to remove the gloves, gather her supplies and leave the room without washing her hands. The nurse was observed to place		reeducated through in-servicing and return demonstration for hand-washing in regards to dressing changes and medication administration. All nursing staff will be reeducated through in-servicing and return demonstration regarding the policy for “Perineal Care” which includes catheter care/maintenance. Continuing education will continue quarterly for hand-washing and catheter care until each staff member has completed four successful return demonstrations. In-servicing will be conducted to introduce updated policies regarding infection control tracking and types of isolation with purpose for use. *MEASURES FOR PREVENTION* All nursing staff will be reeducated through in-servicing and return demonstration for hand-washing in regards to dressing changes and medication administration. All nursing staff will be reeducated through in-servicing and return demonstration regarding the policy for “Perineal Care” which includes catheter care/maintenance. Continuing education will continue quarterly for hand-washing and catheter care until each staff member has completed four successful return demonstrations. In-servicing will be conducted to introduce updated policies regarding infection control tracking and types of isolation with purpose for	

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	the supplies, including the scissors, into the med cart in the hallway and then left the area to get the supplies. Nurse #1 was then observed to return to the medication cart, remove the supplies and the scissors, and enter Resident #43's room. The nurse was observed to again place the supplies directly onto the overbed table. The nurse was observed to put on a new pair of exam gloves without first washing her hands. The nurse again cleaned the resident's buttocks with gauze and normal saline. The nurse picked the scissors up off of the overbed table and cut the Xeroform gauze without cleaning the scissors. The nurse then placed the small pieces of Xeroform gauze directly onto the open areas on the resident's buttocks. The nurse completed the treatment and dressing change, removed the gloves, and then proceeded to wash her hands. The nurse was observed to remove the supplies, including the scissors, from the overbed table and take them out of the room and put them into the medication cart. The undated "Roster Sample Matrix", provided by the Administrator on 8/8/11 at 11:00 a.m., listed 33 residents residing on the 100. The above medication cart contained ointments and treatment materials for the 33 residents residing on the 100 hall who were currently receiving		use. *QA FOR PREVENTION* Logging of completed in-servicing by Staff Development will be reviewed monthly during QA&A meeting to ensure all staff are meeting the required education. Additionally, infection control logs by the Infection Preventionist will be reviewed and presented in the monthly QA&A meeting and written plans will be developed, if necessary, to address any identified infection control trends. *EFFECTIVE DATE*The changes are completed and effective by September 11, 2011. *ADDENDUM* Care plans for residents with infection/possible recurring infections will be updated by Septmeber 11, 2011.	

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	treatments. 2. The record for Resident #43 indicated the physician had diagnosed Resident #43 with urinary tract infections, and had initiated antibiotic therapy, on 5/23/11, 6/13/11, 7/2/11, and 8/1/11. On 8/11/11 at 8:00 a.m., CNA #2 was observed to provide perineal care and catheter care for Resident #43 in her room. CNA #2 was observed to use a wet wash cloth to clean the resident's perineal area. CNA #2 was observed to wipe the resident with the wash cloth, starting near the anal area and toward the perineal area. CNA #2 was then observed to clean the resident's upper inner thighs with a clean wash cloth, wiping from the inner thighs towards the perineal area. CNA #2 was then observed to use a clean wash cloth to clean the catheter tubing, wiping the tubing toward the perineal area. CNA #2 was interviewed on 8/11/11 at 8:30 a.m. after providing the care to Resident #43. During the interview, CNA #2 indicated the during cleaning of a resident's perineal area, the resident was to cleaned from the perineal area outward and from front to back. CNA #2 further indicated the catheter tubing was to be cleaned by wiping from the meatus downward.			

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	155322	A. BUILDING 00 B. WING	08/12/2011

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The Nurse Practitioner (NP) was interviewed on 11/12/11 at 10:45 a.m. During the interview, the NP indicated proper catheter care and perineal care would help reduce the risk of Resident #43 getting urinary tract infections.

A facility policy titled "Perineal Care, with a revision date of April 2011, indicated to clean catheter tubing, staff were to "gently wipe four inches of catheter from meatus out...." The policy further indicated "wipe resident from front to back and from center of perineum to thighs." The policy further indicated that for females staff were to "separate labia, wash urethra area first. Wash between and outside labia in downward strokes, alternating from side to side and moving outward towards the thighs."

The facility infection control nurse was interviewed on 8/11/11 at 3:45 p.m. During the interview, the infection control nurse indicated staff were to wash hands before putting gloves on and after removing gloves. The infection control nurse further indicated that although there was no facility policy addressing the cleaning of scissors, scissors should be cleaned with alcohol or a disinfectant prior to using them to cut dressing materials. The infection control nurse

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	further indicated staff are expected to follow the facility policy on providing catheter care and perineal care. The infection control nurse further indicated that although she was responsible for the surveillance of infections throughout the facility, she had not identified a concern with Resident #43's recurring urinary tract infections and frequent use of antibiotics. The facility's policies on hand washing, dated 2/2011, and wound care, dated 3/2011, did not address washing hands when putting on gloves or when removing gloves during care. 3. On 8/11/11 at 8:10 a.m., LPN #13 was observed administering an insulin injection to Resident 87 while wearing gloves. After removing her gloves, LPN #13 used hand sanitizer rather than soap and water to cleanse her hands before proceeding to administer medication to the next resident. 4. On 8/11/11 at 7:37 a.m., RN #10 was observed administering an insulin injection to Resident #107. After administering the injection, RN #10 removed her gloves and performed a four second hand wash.			

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	5. The Infection Control Nurse was interviewed on 8/11/11 at 2:08 p.m. During the interview, the Infection Control Nurse indicated she had held this position since 9/20/11. She indicated if a resident was placed on an antibiotic for a new infection, the nurse receiving the order for the antibiotic would fill out an infection surveillance report form and place it in the infection control nurse's mailbox. The Infection Control Nurse indicated she would get a copy of the physician's order and progress note, then log the information, including the resident's name, date ordered, type of infection, organism involved, and the antibiotic ordered. She indicated she logged in the infections by hall. The Infection Control Nurse indicated she had completed inservices on infection control for urinary tract infections, glucometer checks, proper peri care, and handwashing. She indicated she did return demonstrations for handwashing, and pericare with the staff inserviced. Review of the infection control inservices for 2011, indicated an inservice for urinary tract infections was completed in January, 2011, an inservice for wound	F0441	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* Resident #43 has been observed for proper treatment and dressing change and is currently receiving appropriate care/maintenance as per facility's policy and procedure for hand-washing and cleaning of utilized equipment. All nursing staff will be reeducated through in-servicing and return demonstration for hand-washing and dressing changes. Additionally, resident #43 has been observed and is receiving proper catheter care/maintenance per facility policy. All nursing staff will be reeducated through in-servicing and return demonstration regarding the policy for "Perineal Care" which includes catheter care/maintenance. LPN #13 and RN #10 have been educated for proper hand-washing after administering an insulin injection. All nurses will be attending in-servicing and return demonstration of hand-washing policies. Review of policies related to infection control and isolation have been reviewed and updated to include individual logs for resident infection tracking and differentiating the different types of isolation with direct explanation of each type of isolation. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* All residents receiving wound care with dressing changes, catheter	09/11/2011

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	care was completed in March 2011, and an inservice for infection control was completed in July, 2011. The Infection Control Nurse indicated she observed and helped the CNAs on the floor, and if she saw something inappropriate, she would talk to the CNAs, but didn't document this. She indicated she was planning on starting a "teachable moment" with staff if she observed concerns with infection control issues. The Infection Control Nurse indicated if a resident was placed on an antibiotic, a red "stop" sign was placed by the resident's door to alert staff the resident was on an antibiotic, and this alerted housekeeping, laundry, and nursing staff that staff were to see the nurse before entering the room. She indicated none of the residents were currently on any kind of isolation precautions. She indicated the same red sign would be used if a resident was on isolation, as the one used if on an antibiotic. She indicated staff would know a resident was on isolation precautions because a cabinet with gowns, gloves, and supplies for isolation would be placed outside the resident's room, and staff would also receive the information in report from the nurses.		care, and those receiving medication after insulin injections have the potential for risk. Additionally, all residents have the potential for risk for recurrent infection. All nursing staff will be reeducated through in-servicing and return demonstration for hand-washing in regards to dressing changes and medication administration. All nursing staff will be reeducated through in-servicing and return demonstration regarding the policy for “Perineal Care” which includes catheter care/maintenance. Continuing education will continue quarterly for hand-washing and catheter care until each staff member has completed four successful return demonstrations. In-servicing will be conducted to introduce updated policies regarding infection control tracking and types of isolation with purpose for use. *MEASURES FOR PREVENTION* All nursing staff will be reeducated through in-servicing and return demonstration for hand-washing in regards to dressing changes and medication administration. All nursing staff will be reeducated through in-servicing and return demonstration regarding the policy for “Perineal Care” which includes catheter care/maintenance. Continuing education will continue quarterly for hand-washing and catheter care until each staff member has	

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	155322	A. BUILDING 00 B. WING	08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	The Infection Control Nurse indicated the facility did not have specific isolation procedures for the different types of isolation, such as contact isolation, but standard isolation procedures were used, and the nurse would notify staff regarding the specific type of isolation for the resident. She indicated if contact isolation for a resident with methicillin resistant staphylococcus aureus (MRSA) in a wound was used, a dresser would not necessarily be utilized, but a red bag and glove would be placed in the room. She indicated she completed infection control logs every month, and gave a copy to the Administrator and Director of Nursing Services, then discussed infection control quarterly at the quality assurance meetings. The infection report logs for June 2011 and July 2011 were reviewed with the Infection Control Nurse. In June, five residents on the 100 hall were noted to have urinary tract infections, and in July, five residents on the 100 hall were listed on the infection log as having urinary tract infections. The infection control nurse indicated she did not track recurrent infections, but for July 2011, she noticed the same resident		completed four successful return demonstrations. In-servicing will be conducted to introduce updated policies regarding infection control tracking and types of isolation with purpose for use. *QA FOR PREVENTION* Logging of completed in-servicing by Staff Development will be reviewed monthly during QA&A meeting to ensure all staff are meeting the required education. Additionally, infection control logs by the Infection Preventionist will be reviewed and presented in the monthly QA&A meeting and written plans will be developed, if necessary, to address any identified infection control trends. *EFFECTIVE DATE*The changes are completed and effective by September 11, 2011. *ADDENDUM* Care plans for residents with infection/possible recurring infections will be updated by Septmeber 11, 2011.	

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	names kept coming up on the infection control logs, and noticed a lot of infections on the 100 hall. She indicated she planned on meeting with the Director of Nursing and Assistant Director of Nursing to put something together to track the infections. She indicated she had not done this in the past. She indicated she had logged the infections and causative agents, but had not been following up and tracking why so many urinary tract infections were occurring on the 100 hall. The Environmental Director was interviewed on 8/12/11 at 9:55 a.m. During the interview, she indicated there were no residents on isolation at this time, however, Resident #107 had a dressing change and staff were supposed to gown and glove to do the dressing change. She indicated the cabinet with gowns and gloves was located in the resident's room. On 8/12/11 at 10:00 a.m., with the Environmental Director and Maintenance Man #19 a small plastic cabinet was observed in Resident #107's room, in a small open area, to the right of the closet. The drawers of the cabinet were observed to have gowns, masks, and gloves. The Environmental Director indicated these were used for dressing changes only, and the resident was not on isolation. RN #6 was interviewed on 8/12/11 at			

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	155322	A. BUILDING 00 B. WING	08/12/2011

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	10:30 a.m. RN #6 indicated Resident #107 had surgery on her ankle and was admitted to the facility with a diagnosis of methicillin resistant staphylococcus aureus (MRSA) in the right ankle, and was receiving vancomycin (an antibiotic) intravenously once every night. She indicated the resident was admitted to the facility with physician orders for contact precautions. She indicated the MRSA was contained, as the resident had a dressing and ace wrap and wore a special boot on her foot, and nursing did not change the dressing until 8/9/11. She indicated on 8/9/11, the resident had a doctor's appointment, and the physician changed the dressing, then left orders for nursing staff to start changing the dressing. She indicated the resident had the first dressing changed at the facility on 8/10/11. She indicated contact isolation was ordered on admit, however, nursing was using universal precautions until 8/9/11. She indicated after 8/9/11, the resident still remained on contact isolation, but the nurses were the only ones in contact with the dressing, and they wore gowns, gloves, and a mask. She indicated on 8/9/11, one of the nurses placed the plastic cabinet in the resident's room, which contained the gowns, masks, and gloves. She indicated the CNAs did not wear gowns for this resident because the MRSA was contained in the dressing.			

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	The Infection Control Nurse was interviewed on 8/12/11 at 1:15 p.m. During the interview, she indicated she was logging the infections monthly, with the causative organisms, but not investigating to determine if follow-up or inservicing for staff was needed. She indicated the facility did not have a specific isolation policy for contact isolation, or MRSA, except for respiratory MRSA, but the facility used the "standard" precautions. She indicated if a resident was on contact isolation for MRSA, she would expect gloves and gowns to be worn with care. She indicated she was not aware Resident #107 was on contact precautions for MRSA as she had not received an infection surveillance form from the nurse. She indicated normally gowns and gloves would be placed in a dresser outside of the resident's room. The infection surveillance report form, was reviewed with the Infection Control Nurse at 1:30 p.m. on 8/12/11. She indicated she had gotten this on 8/12/11, from RN #6. She indicated RN #6 had made the form out when the resident was admitted to the facility, but did not give it to the infection control nurse. The form was dated 8/1/11, and indicated the resident was to receive vancomycin every			

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	24 hours for six weeks due to MRSA in an ankle wound. The form also indicated the resident was to be on contact precautions. The record for Resident #107 was reviewed on 8/12/11 at 1:50 p.m. Physician orders dated 8/1/11, indicated contact precautions. At the time of the record review, there were no care plans indicating the resident was to be on contact precautions. The Minimum Data Set (MDS) Assessment Nurse, was interviewed on 8/12/11 at 1:55 p.m. During the interview she indicated she was not aware the resident was to be on contact precautions so did not indicate this on the care plan. RN #6 was interviewed and indicated if a CNA saw drainage on a bedsheet, no matter what the drainage, the CNA would not touch the drainage, and would be careful and bag the sheet and take it to the laundry barrels kept in the shower rooms. She indicated she would tell the CNAs if a resident was on isolation precautions, but this was still standard precautions. She also indicated only the nurses were doing the dressing changes on the resident, and if the resident did have drainage from the wound area, which the CNAs could come in contact, a dresser would be placed outside of the resident's			

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	room. 3.1-18(b)(1) 3.1-18(j) 3.1-18(l)			
F0465 SS=D	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review and interview, the facility failed to ensure 1 of 3 refrigerators in 1 of 1 medication storage rooms were clean and without spillage. Findings include: During an observation of the medication storage room with the Director of Nursing on 8/10/11 at 1:00 p.m., the following was observed: a full refrigerator containing pitchers of juice, applesauce and pudding. A spilled orange sticky substance was observed covering the bottom shelf in the refrigerator and down into the bottom drawers. An interview was conducted with the Director of Nursing on 8/10/11 at 1:14 p.m. During the interview, after making a call to the Housekeeping Supervisor, the Director of Nursing indicated	F0465	**F465 CORRECTIVE ACTION FOR AFFECTED RESIDENTS:** Refrigerator located in medication room cleaned 8/10/11. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** Refrigerator will be monitored daily for spills and cleaned as needed. **MEASURES FOR PREVENTION:** Housekeeper will check daily and clean any spills in med room refrigerator. **QA FOR PREVENTION:** Environmental manager will monitor on a weekly basis for 3 months and report any concern to QA committee **EFFECTIVE DATE:** September 11, 2011	09/11/2011

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	Housekeeping cleans the refrigerator every other week. The current policy and procedure for "Cleaning Med Room," dated 6/9/10, was provided by the Housekeeping Supervisor on 8/10/11 at 2:23 p.m. The policy listed the following: "...to maintain a clean environment and thereby prevent the spread of infection...Bi-weekly...clean refrigerator with bactericidal solution and clean cloths...." 3.1-19(f)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure accurate documentation of medication refills for 1 of 10 residents reviewed for medication orders. (Resident #20) Findings include:	F0514	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* The pharmacy has been contacted and updated with the correct dosing information for resident #20. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY*	09/11/2011

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	A hand written prescription for oxybutynin (overactive bladder medication), dated 8/3/11, was signed by the Assistant Director of Nursing. The order indicated Resident #20 was to receive oxybutynin 5mg (milligrams) daily. The "Routine Meds" sheet, dated August 2011, indicated Resident #20 was receiving oxybutynin 5mg twice daily. A "New Prescription Request" form, dated 8/4/11 from the pharmacy, indicated an order for oxybutynin 5mg daily. An interview was conducted with the Director of Nursing (DON) on 8/10/11 at 9:30 a.m. During the interview, the DON indicated the prescription was completed by the Assistant Director of Nursing (ADON) and sent to the pharmacy for refilling the medication but the order had not been refilled yet. She further indicated a pharmacy clarification needs to be sent to the pharmacy since the oxybutynin should be listed for twice daily and not daily. 3.1-50(a)(2)		*AFFECTED RESIDENTS* All residents who have outside pharmacy or those being discharged with handwritten prescriptions have the potential for risk. All prescriptions generated by the DON/ADON will be logged and double checked for accuracy. *MEASURES FOR PREVENTION* All prescriptions generated by the DON/ADON will be logged and double checked for accuracy by another staff member. *QA FOR PREVENTION* The log will be monitored by the DON or designee every time a new prescription is written and presented monthly during the QA&A meeting. *EFFECTIVE DATE* The changes are completed and effective by September 11, 2011.	

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F0518 SS=D	The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. Based on interview and record review, the facility failed to ensure 1 of 3 staff interviewed for emergency procedures was knowledgeable of the facility's fire procedure plan. (Employee #18) Findings include: 1. Employee #18 was interviewed on 8/12/11 at 1:30 p.m., with Maintenance Man #19 and the Environmental Director. Employee #18 indicated if there was a fire in the dryer in the laundry room, the employee would try to extinguish the fire then go to the nurse's station to report the fire. Review of the undated policy for fire procedures, provided by Maintenance Man #19 on 8/12/11, did not cover procedures for fires in the laundry room, however, a policy provided by the Environmental Director titled, "Emergency shut off procedure laundry," indicated "Gas: In the event of an emergency the main gas shut off is outside at the end of the north hall. An adjustable wrench is hanging outside at the shut off valve. Place wrench on valve and turn 1/4	F0518	**F518 CORRECTIVE ACTION FOR AFFECTED RESIDENTS** Employees working in laundry will be in-serviced on facility's fire procedure plan and be able to demonstrate verbal knowledge. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** All resident have the potential to be affected. Staff training will be completed. **MEASURES FOR PREVENTION:** Laundry employees will receive training upon hire and yearly specific to laundry department regarding facility fire procedure plan. Emergency gas shut off procedure posted in laundry area for quick referral. **QA FOR PREVENTION** Training upon hire and yearly including specific laundry and gas shut off in case of emergency. Environmental Manager to observe annual gas shut off return demonstration by laundry employees and report results and recommendations to QA&A committee. **EFFECTIVE DATE** September 11, 2011	09/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	turn counter clockwise." Review of the facility orientation on 8/12/11 for Employee #18, indicated the employee had been orientated to disaster and emergency procedures on 1/24/11. 3.1-51(b)			
F0520 SS=F	A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, record review, and interview, the facility failed to ensure the QA&A (Quality Assurance and	F0520	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* QA&A meetings will continue monthly as per facility policy with the medical	09/11/2011

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	Assessment) Committee identified potential infection control concerns. This had the potential to affect 88 of 88 residents residing in the facility. Findings include: 1. The Infection Control Nurse was interviewed on 8/11/11 at 2:08 p.m. During the interview, she indicated if a resident was placed on an antibiotic for a new infection, the nurse receiving the order for the antibiotic would fill out an infection surveillance report form and place it in the Infection Control Nurse's mailbox. The Infection Control Nurse indicated she would get a copy of the physician's order and progress note, then log the information, including the resident's name, date ordered, type of infection, organism involved, and the antibiotic ordered. She indicated she logged in the infections by hall. The infection report logs for June 2011 and July 2011 were reviewed with the Infection Control Nurse. In June, five residents on the 100 hall were noted to have urinary tract infections, and in July, five residents on the 100 hall were listed on the infection log as having urinary tract infections.		director and pharmacy consultant attending quarterly. The QA&A meeting will include the logging of infections by individual resident and potential concerns related to recurrent infections. Prior policies will continue to be followed in tracking of infections. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* All residents have the potential to be at risk. The QA&A meeting will include the logging of infections by individual resident and potential concerns related to recurrent infections. Prior policies will continue to be followed in tracking of infections. *MEASURES FOR PREVENTION* QA&A meetings will continue monthly as per facility policy with the medical director and pharmacy consultant attending quarterly. The QA&A meeting will include the logging of infections by individual resident and potential concerns related to recurrent infections. Prior policies will continue to be followed in tracking of infections. *QA FOR PREVENTION* During the QA&A meeting, minutes and plan of action, if necessary, will be written to ensure all potential concerns have been addressed. *EFFECTIVE DATE*The changes are completed and effective by September 11, 2011.	

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	The Infection Control Nurse indicated she did not track recurrent infections, but for July 2011, she noticed the same resident names kept coming up on the infection control logs, and noticed a lot of infections on 100 hall. She indicated she planned on meeting with the Director of Nursing and the Assistant Director of Nursing to put something together to track the infections. She indicated she had not done this in the past. She indicated she had logged the infections and causative agents, but had not been following up and tracking why so many urinary tract infections were occurring on 100 hall. 2. The record for Resident #43 was reviewed on 8/10/11 at 1:00 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, pemphigus bullous (chronic autoimmune skin disease involving the formation of blisters), and urinary retention. On 8/10/11 at 1:30 p.m., RN #1 was observed to provide a treatment and dressing change on the buttocks of Resident #43. Resident #43 was observed in her room, lying in bed on her left side. The resident's buttocks were observed to be reddened with three superficial open areas.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN46814

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	RN #1 was observed to place her supplies, including scissors, directly on the overbed table. RN #1 was observed to put on exam gloves without first washing her hands. The nurse was observed to clean the resident's buttocks with gauze and normal saline. The nurse picked up the scissors from the overbed table and used them to cut Xeroform gauze (petroleum covered gauze) without disinfecting the scissors. The nurse then placed small pieces of the gauze onto the open areas on the resident's buttocks. The nurse then placed the scissors directly onto the overbed table. The resident then began to have a bowel movement. The nurse removed the gloves and went a dresser in the room and removed a roll of toilet paper. The nurse did not wash her hands after removing the gloves. The nurse then put on a new pair of exam gloves without first washing her hands and proceeded to use the toilet paper to wipe the resident's buttocks. The nurse then indicated she had to get some more supplies. The nurse was observed to remove the gloves, gather her supplies and leave the room without washing her hands. The nurse was observed to place the supplies, including the scissors, into the medication cart in the hallway and then left the area to get the supplies. RN #1 was then observed to return to the medication cart, remove the supplies and the scissors, and enter Resident #43's			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	room. The nurse was observed to again place the supplies directly onto the overbed table. The nurse was observed to put on a new pair of exam gloves without first washing her hands. The nurse again cleaned the resident's buttocks with gauze and normal saline. The nurse picked the scissors up off of the overbed table and cut the Xeroform gauze without cleaning the scissors. The nurse then placed the small pieces of Xeroform gauze onto the open areas on the resident's buttocks. The nurse completed the treatment and dressing change, removed the gloves, and then proceeded to wash her hands. The nurse was observed to remove the supplies, including the scissors, from the overbed table and take them out of the room and put them into the medication cart. 3. The record for Resident #43 indicated the physician had diagnosed Resident #43 with urinary tract infections, and had initiated antibiotic therapy, on 5/23/11, 6/13/11, 7/2/11, and 8/1/11. On 8/11/11 at 8:00 a.m., CNA #2 was observed to provide perineal care and catheter care for Resident #43 in her room. CNA #2 was observed to use a wet wash cloth to clean the resident's perineal area. CNA #2 was observed to wipe the resident with the wash cloth,			

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	155322	A. BUILDING 00 B. WING	08/12/2011

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starting near the anal area and toward the perineal area. CNA #2 was then observed to clean the resident's upper inner thighs with a clean wash cloth, wiping from the inner thighs towards the perineal area. CNA #2 was then observed to use a clean wash cloth to clean the catheter tubing, wiping the tubing toward the perineal area.

CNA #2 was interviewed on 8/11/11 at 8:30 a.m. after providing the care to Resident #43. During the interview, CNA #2 indicated during the cleaning of a resident's perineal area, the resident was to be cleaned from the perineal area outward and from front to back. CNA #2 further indicated the catheter tubing was to be cleaned by wiping from the meatus downward.

The Nurse Practitioner (NP) was interviewed on 11/12/11 at 10:45 a.m. During the interview, the NP indicated proper catheter care and perineal care would help reduce the risk of Resident #43 getting urinary tract infections.

A facility policy titled "Perineal Care," with a revision date of April 2011, indicated to clean catheter tubing, staff were to "gently wipe four inches of catheter from meatus out...." The policy further indicated "wipe resident from front

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	to back and from center of perineum to thighs." The policy further indicated that for females, staff were to "separate labia, wash urethra area first. Wash between and outside labia in downward strokes, alternating from side to side and moving outward towards the thighs." The facility Infection Control Nurse was interviewed on 8/11/11 at 3:45 p.m. During the interview, the Infection Control Nurse indicated staff were to wash hands before putting gloves on and after removing gloves. The Infection Control Nurse further indicated that although there was no facility policy addressing the cleaning of scissors, scissors should be cleansed with alcohol or a disinfectant prior to using them to cut dressing materials. The Infection Control Nurse further indicated staff are expected to follow the facility policy on providing catheter care and perineal care. The Infection Control Nurse further indicated that although she was responsible for the surveillance of infections throughout the facility, she had not identified a concern with Resident #43's recurring urinary tract infections and frequent use of antibiotics. The facility's DON was interviewed on 8/12/11 at 2:00 p.m. During the			

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	interview, the DON indicated she was the head of the facility's Quality Assurance and Assessment (QAA) Committee. During the interview, the DON indicated the committee included, but was not limited to, facility department heads, the Medical Director, and the consultant Pharmacist. She also indicated the committee meets monthly with the facility staff and quarterly with the Medical Director. The DON indicated the purpose of the committee was to identify possible concerns related to resident care. The DON indicated concerns could be brought to the attention of the committee by the various departments or by individuals. The DON indicated if a concern was identified, the committee would analyze the problem and would then initiate an action plan to correct the problem. The DON indicated any potential concerns with infections and the use of antibiotics would be identified by the Infection Control Nurse, who would then bring the issue to the attention of the QAA committee. The DON indicated the Infection Control Nurse had not brought any infection control issues to the committee. The DON indicated the committee had not identified Resident #43's recurrent UTI's and frequent use of antibiotics, hand washing, or improper catheter care techniques as a potential concern.			

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